RESEARCH PAPER

Am I competent enough to be doing this?: A qualitative study of trainees’ experiences working with clients who self-injure

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This study examined the experiences of counsellors in training working with clients who present with non-suicidal self-injury (NSSI) as a basis for understanding how trainees react to and resolve the challenges presented by difficult counselling cases. A qualitative data analysis using consensual qualitative research [Hill, C.E., Knox, S., Thompson, B.J., Nutt Williams, E., Hess, S.A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, 52, 196–205; Hill, C.E., Thompson, B.J., & Nutt Williams, E. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist*, 25, 517–572] was conducted on 12 transcribed interviews of Master’s level trainees who had recently worked with at least one client who self-injured. Three general themes were reflected by the data. Specific to NSSI the findings revealed that trainees created an intuitive model of NSSI that reflected some understanding of the phenomenon despite little or no prior exposure to it. With regard to the work involved in these challenging cases, trainees reported a number of personal struggles and tasks that they needed to resolve while trying to be helpful to these clients. These tasks included managing their emotional reactivity and resolving ethical and confidentiality issues. Engaging in these two tasks heightened their feelings of uncertainty yet also focused them to be highly intentional in their work. Whereas supervision often serves novices well when they struggle, participants reported that supervision only partly alleviated the difficulties they faced. Implications and limitations of these findings are discussed.

Keywords: self-injury; novice clinicians; counsellors in training; supervision and training of counsellors and therapists

Introduction

Clinical educators, trainers and supervisors have always been interested in understanding the processes that trainees move through as they undergo formal training and supervision (Skovholt & Ronnestad, 2003). Central to this educational process is the trainee’s actual work with clients. Trainees (and experienced practitioners) often nominate their clinical experiences as key to their professional growth and continued competence (Orlinsky, Botermans, & Ronnestad, 2001; Ronnestad & Skovholt, 2003; Stahl et al., 2009). Yet, trainees inevitably find themselves working with a clientele that tests the limits of their knowledge and

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abilities. For example, Rodenhauser (1994), in speaking about psychiatry residents, talks about how some difficult patients may elicit emotional reactions in trainees that make treatment and supervision difficult. Thus, the clinical management of clients who are experienced as difficult or challenging represents an important training goal for all trainees (Hill & Lent, 2006; Hill, Stahl, & Roffman, 2007; Spruill et al., 2004).

Clients who present with self-injury, whether it is with or without suicidal intent, could certainly be considered “challenging” to counsellors in training. Self-injury is here defined as the deliberate and self-inflicted destruction of body tissue (cutting, bruising, hitting) resulting in immediate damage without a culturally sanctioned purpose (Favazza, 1996; Walsh, 2006). A further distinction is made with regard to the motivations for self-injury and so where suicide is clearly not the intent the term non-suicidal self-injury (NSSI) is used (Walsh, 2006). It was once thought that self-injury occurred only among clinical populations and that it was a clear manifestation of psychopathology (Favazza, 1996). This view is changing in part through the growing awareness that prevalence rates among non-clinical populations are quite high. For example, between 15% and 20% of adolescent populations studied and 12% and 17% of college age students engaged at least once in some type of self-injury (Heath, Schaub, Holly, & Nixon, 2009; Heath, Toste, Nedecheva, & Charlebois, 2008; Whitlock, Eckenrode, & Silverman, 2006). Given this reality, it is likely that community-based mental health practitioners like school counsellors and psychologists will be the first line of professionals dealing with clients who present with NSSI.

Regardless of the service setting, practitioners have to respond promptly to the ethical and legal issues inherent in a disclosure of self-injury. In most jurisdictions, they are required to take action if danger is imminent but where the intent is not clear this presents a dilemma (White, McCormick, & Kelly, 2003). This not only challenges the clinician’s ability to intervene but it raises many questions about the reliability of the client’s narrative and in differentiating when the self-injury is without suicidal intent. The distinction between suicidal and non-suicidal is further complicated by the possibility that repeated NSSI behaviours might increase the risk of suicide (Muehlenkamp & Guitererz, 2004; Muehlenkamp & Kerr, 2010; Stanley, Gameroff, Michael, & Mann, 2001; Suyemoto, 1998).

Adding to the ethical challenges is the clinical reality that NSSI can elicit negative reactions from many practitioners (Gratz, 2003; Nathan, 2006; Walsh, 2006). The shock or surprise of a client’s disclosure may easily alarm those unwilling or unprepared to hear details of cutting, bruising and bleeding. There is ample evidence, especially from the nursing and medical literature, of the negative reactions that precede or accompany clinical work with patients who self-injure (McAllister, Creedy, Moyle, & Farrugia, 2002; Thompson, Powis, & Carradis, 2008). For example, Thompson et al.’s (2008) qualitative study describes the shock, disgust and sadness of psychiatric nurses working with these patients.

Unexpected and unwanted reactions can interfere with treatment in that clients may interpret this reaction as a lack of understanding or openness and they may regret their disclosure and reconsider their decision to seek help. Thus, it should not surprise us that these individuals often report unsatisfactory experiences in their contacts with the mental health system (Warm, Murray, & Fox, 2002). Clinicians who mistakenly see the injuring behaviour as manipulative, as a form of grandstanding or attention seeking, may unwittingly erect obstacles to treatment and progress (Bowers, 2003; Gratz, 2003). In fact, the practitioner’s self-monitoring
of his or her affective responses can be considered an important guideline that must be adhered to. We are beginning to see work that addresses precisely how these countertransference feelings must be mastered in order to assure competent and effective counselling for individuals with NSSI (Nafisi & Stanley, 2007; Nathan, 2006; Rayner, Allen, & Johnson, 2005).

For the foregoing reasons we believed that clients presenting with self-injury stretch the boundaries of a beginner’s competence. Examining the trainees’ experiences as they work in this context would allow us to gain insight into how stress and challenge impact the experiences of the trainee and further our understanding of those factors that contribute to the learning of complex skills – whether these are specific to NSSI or to the more general practice of counselling. These findings could be of interest to supervisors since they are responsible for both the trainee’s development and the client’s safety. Our focus for the study was essentially exploratory and discovery oriented and was framed by two overarching questions: (1) How do trainees describe and understand their experiences of working with these challenging clients? and (2) What can these experiences tell us about their evolving clinical development and learning?

As is customary in qualitative research, researchers are required to track and state their biases prior to and during the study. We had the expectation that novice practitioners would experience emotional reactivity as part of this highly challenging and uncertain work. We also had the anticipation that difficult scenarios (when resolved) would lead to significant learning, not only about the work of counselling, but also about themselves as clinicians. We were also hopeful that qualitative data on this topic would have some heuristic value in expanding our understanding of the training and supervision of novice clinicians.

**Method**

**Participants and description of sites**

Participants for the study were a sample of convenience recruited from a cohort of second-year MA students in the counselling psychology programme of a large Canadian university. The criterion for participation was that the trainee had worked with one or more clients who had engaged in some form of self-injury within the last nine months. All students were in the final weeks of their internship at the time of recruitment. As part of their degree, students are required to complete a three-day per week internship in a community setting where the goal is to complete 600 hours of clinical practice. The most popular internship sites are high schools, colleges and university counselling centres. The purpose of the internship is to allow trainees to work under supervision with a broad spectrum of clients typical of the setting. Twelve trainees from the initial cohort of 27 met the criterion and agreed to participate.

All of the 12 participants were women. They were of Anglo-European background and ages ranged from 23 to 37 years. None had any substantive clinical experience beyond their initial training in a practicum in counselling psychology, and all of them had completed the same course of study for the MA in counselling psychology.

Internship sites were made up predominately of high schools ($N = 7$) with a range in student enrolment of 500–1300. The majority of these schools ($N = 6$) were
described as multiracial and multiethnic and only one was identified as having a predominately Caucasian student body. The other sites were made up of two university counselling centres of large urban universities, a community college of 1500 students, a government funded addictions service and a small specialized high school for students with behavioural problems.

Supervision of these trainees was provided by an on-site supervisor, a senior or experienced practitioner worked at the site providing counselling services. Every week trainees received between one and two hours of individual site supervision and three hours of group supervision with a university faculty member throughout their internship (two semesters).

Procedures

One of the researchers recruited participants by addressing an entire MA cohort during their time in class with an instructor not involved in the study. Following a description of the study, students were invited to participate if they had provided ongoing counselling to at least one client who presented with self-injuring behaviours. Project consent forms that included a statement of ethics approval were placed in the student mailboxes and interested students returned the completed consent forms with contact information to a research assistant.

Data were generated through the use of a semi-structured interview. A pilot interview was conducted to test and refine the interview protocol. This pilot interview was not transcribed, nor was it used in data analysis. The interview protocol consisted of open-ended questions about their reactions, thoughts and feelings when working with these clients and participants were encouraged to elaborate fully on their experiences. The interviewer was a fourth-year PhD student in school psychology. The interviews were between 45 and 60 minutes in length and all were recorded and transcribed for data analysis. The questions in the interview protocol asked participants about the following areas: (a) their understanding of self-injury, (b) their ideas about how prevalent it was in the population, (c) their experiences working with clients who self-injure, (d) the interventions they used and the outcomes of these interventions, (e) their feelings in response to these clients, (f) the supervision they received with regard to these clients and finally (g) their ideas about how they would intervene with this clientele in the future.

Data analysis

Consensual qualitative research (CQR; Hill et al., 2005; Hill, Thompson, & Nutt-Williams, 1997) was used to analyse the interview transcripts. CQR is extensively used in counselling and psychotherapy research to study a broad range of phenomena (Ponterotto, 2005). This methodology was influenced by Glaser and Strauss’ (1967) development of grounded theory and thus uses a constant comparison method to make ongoing judgements among the data to derive meanings from the participants’ experiences. Unlike grounded theory, CQR uses a team of researchers to reach consensus among the ratings and these ratings are checked by an auditor.

The team responsible for the data analysis comprised of one MA student in school psychology and two faculty members in counselling psychology. All members
worked independently to read the transcripts and to devise the initial domains and core ideas. As suggested by Hill and colleagues (1997), each member stated what she or he expected to find in the study as a way of ensuring that biases did not unduly influence the results. Every team meeting started with a discussion of biases, reactions and ideas. These were recorded as notes for constant review and discussion. The data analysis went through the following steps.

**Domains.** Initially all three team members independently read and reread one transcript picked at random and took notes of impressions, thoughts and questions. The first consensus meeting was used to decide the initial set of domains. These domains were used to manage the large amount of information that emerged from the interviews. When a potentially new domain emerged this was discussed and consensus was reached. The domains were (a) understanding of NSSI, (b) previous exposure to the literature on NSSI, (c) reactions to NSSI disclosure, (d) their efficacy and (e) their current understanding. Pairs of raters read a transcript independently and coded the material according to the domains (Strauss & Corbin, 1990). Subsequently, consensus meetings were held to compare codes and to derive a final code. A third rater audited each interview. This task was equalized among all three members so that they all served in the role of both rater and auditor.

**Open codes.** Each team member independently read a statement of a domain and condensed and re-wrote the participants’ statements in such a way as to retain the main idea or meaning. Open coding stays very close to the participant’s statement and their words and phrases are often kept intact. Consensus was sought between pairs of raters for each participant statement. Once consensus had been reached, the auditor independently read the transcripts and compared the open codes to the original text to establish that these captured the participants’ narratives. High agreement between the consensus team and the auditor suggested that the researchers had been accurately interpreting the data. Where the auditor did not agree with the codes, the discrepancy was discussed and a point of consensus was reached. These data were then subjected to a cross-case analysis by the original team.

**Cross-case analysis.** Cross-case analysis was used to compare every participant’s core ideas across all participants and to organize core ideas into similar clusters of meaning. This process was audited again to ensure that the emerging themes reflected the data and to discuss new or different themes that better fit the data. As with each preceding stage of analysis, consensus was reached through discussions at each step of the process.

**Trustworthiness and dependability**

Several strategies were employed to enhance the quality of this study. Research credibility refers to the likelihood that credible findings and interpretations will be produced (Lincoln & Guba, 1985; Merrick, 1999). The credibility of this study was enhanced in a number of ways. Audio recording and verbatim transcription of all the interviews ensured the accuracy and completeness of the data. Additionally, in keeping with Johnson’s (1997) recommendations regarding critical self-reflection of predispositions that may affect the research process or conclusions, we clearly stated the assumptions we brought to this study beforehand and used notes to provide an audit trail of assumptions as they developed throughout this research.
These assumptions were discussed at consensus meetings and a team member kept track of them as they were discussed. Consensus meetings were an important part of the data analysis and we regularly discussed our reactions to the data to ensure that we were accurately reflecting the participants’ meanings and that we were being tentative with our ideas until we were more confident of their importance. Furthermore, debriefing and auditing (within our own team) were used continuously to confirm that our interpretations were directly supported by the data.

The dependability of this research was accentuated by maintaining a clear and detailed trail of all data, memos, coding, categorizing, diagrams and theorizing so that the process and product of this study can be audited. We also reported quotes and examples from the data to support obtained results. In reporting quotes, speech repetitions, filled pauses (“umhs”, “like”) and hesitations of participants were eliminated to make for shorter and more readable quotes. By providing thorough descriptive data, readers can determine if the results generalize to the settings in which they work.

Results

The research questions for this study revolve around the experiences of counsellors in training working with challenging clients, in this case, those clients who self-injure. Our analyses of the interviews describe how novices make sense of an unfamiliar clinical phenomenon (i.e. NSSI) and how they navigate the tasks involved in active treatment of these clients. Our findings describe three general themes: (1) trainees construct a basic, model of NSSI despite lack of previous knowledge of the phenomenon; (2) work with NSSI challenges the trainee at many levels and (3) experience provides new but incomplete learning. Within these specific themes there were a number of subthemes. Both themes and subthemes are displayed in

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Note: “General” refers to themes and subthemes endorsed by 11 or 12 participants and “Typical” refers to endorsements by 7–10 participants.
Table 1. Following Hill and colleagues (2005), each theme was categorized according to how often it was endorsed by participants. A theme was considered to be “general” if it occurred in all cases or in all cases except one (i.e. 11 or 12 cases), “variant” if it occurred in half of the cases or less (i.e. six or less) and “typical” if it occurred between “variant” and “general” (i.e. 7–10 cases).

**Theme 1: Trainees use common sense to construct a basic model of NSSI despite lack of previous knowledge of the phenomenon**

This theme and its subthemes underscore the extent to which beginners rely on their intuition and a common-sense conceptualization of NSSI. None of our trainees had reported having had academic or practical exposure to NSSI yet their descriptions revealed an intuitive or instinctual understanding of NSSI and to some extent, how to proceed with the work. Thus, while their actual knowledge base of NSSI was quite rudimentary and in most cases contained incomplete, erroneous information from dubious sources (e.g. daytime TV programme), they still managed to construct a working model for their own purposes. The elements of that working model are illustrated in the following two subthemes: NSSI is conceptualized as a poor coping mechanism and establishing an empathic attitude was seen as essential in helping clients explore aspects of their self-injury.

**Subtheme 1a: NSSI is seen as a way to cope with psychological distress**

Every participant described NSSI as a functional behaviour, and they generally saw it as the client’s inability to cope with distressing emotions. How trainees actually expressed this idea revealed considerable range of sophistication. For example, one participant saw NSSI as a means to manage distress or negative emotions.

> I guess you could say it’s a maladaptive coping mechanism that people use for various reasons, including when they have difficulty, well one there’s self-hatred involved... when they have difficulty expressing emotion and it’s a way of making their feelings more real or making their experiences seem more real.

Participants typically referred to developing their treatment plans based on a distress/coping understanding of NSSI; more than half spoke of their efforts to reduce their clients’ anxiety, and to use the therapeutic alliance as a means of facilitating emotional expression. They also sought to identify and deal with what was triggering the NSSI.

> We talked about how cutting was actually in some ways helpful for him, it was a relief. But we did a pros and cons exercise. And he identified a number of cons that maybe outweighed the pros...and we talked about different ways of coping.

**Subtheme 1b: Empathy is the correct response to distress**

The second subtheme suggests that while acknowledging their inexperience, trainees relied primarily on an interpersonal focus of providing validation and understanding. Thus, the immediate response of adopting an attentive and empathic posture was familiar to them, and the intentional use of these relational skills instilled in them a sense of control and competence. They generally referred to this as “following their instincts” to “give the clients space to express themselves” and “validate them”
perhaps without fully recognizing the indispensible value of empathy to an individual in distress. Some of this is captured in the following:

I really wanted to make sure that I was making her feel okay about talking to me about it. I knew that other people have probably had a reaction of fear towards her, and I really wanted to make sure that even though she wasn’t a hundred percent comfortable talking to me about it, I really wanted her to feel like it was a place that if she wanted to talk to me about it, she could, and if she wanted to show me any of her scars or any of her cuts, she could do that too.

More specifically, this interpersonal focus seemed to have a threefold benefit: it facilitated alliance building, helped the counsellor manage her own emotionality in the session and opened up the discussion about the client’s self-injury. While these three elements were not part of the experiences of all the participants, they were reflective of how the participants understood their work with these clients. One participant talked about how she changed as a result of establishing a trusting bond with the client.

I think my emotional reactions were different because I had a different relationship with her by then so my emotional reactions were more understanding. I was concerned about suicidal risk, but in a less panicked sort of way. I felt more confident in my relationship with her, I felt I was able to trust her to disclose and be honest so, rather than try and hide things from me, that she had in the beginning of our relationship. So I really felt better, because I felt a better connection with her, my concern was less panicked.

In summary, all of the trainees in this study were able to formulate an understanding (albeit rudimentary) of what NSSI was and its function for the client. Thus many understood conceptually that helping the client cope with distress was desirable, but the focus of their work was mostly on facilitating the client’s expression of emotion. While a few participants expressed a wish for more specific interventions to target the NSSI, they generally relied on generic interventions such as validation to create a non-judgmental discussion of the clients’ concerns.

Theme 2: Work with NSSI stress and challenge trainees at many levels

The second theme captured more fully the difficult experience of working with NSSI and describes the multiple obstacles that had to be overcome in the process of helping these clients. This theme becomes differentiated through four subthemes which illustrate how the experience of confronting the challenges of working with NSSI elicited intense emotions, feelings of incompetence and questions of ethics that combined to focus and heighten their attention.

Subtheme 2a: NSSI provokes powerful, multiple emotions in trainees

This is a general theme that was described by all participants. It would seem that shock and sadness, usually in tandem, were the initial reactions to NSSI. While sadness was indeed universal, other negative emotions often accompanied the work, either at disclosure or at other times. These included anxiety about being unprepared to help the client effectively, discomfort with the details of the injuries, concern for the client’s safety and disappointment when there were relapses. Despite their intellectual understanding of NSSI as a maladaptive means of coping, participants were nonetheless universally shocked when confronted with the actual details.
When asked about the salient aspect of the first meeting one participant gave a series of hesitant remarks that exemplifies the difficulty she had putting words to her emotions. The participant responded:

Her scars . . . That'll, that'll never leave me . . . I was just trying to kind of get an idea of who she was. I actually knew that she had been cutting. My supervisor had informed me, but I chose to wait on that and see if that was something she felt comfortable bringing out to me instead of me saying “well I know all this stuff about you” . . . the biggest thing was just her age. It was just so salient to me because she was thirteen and when I think to myself about being thirteen, those kind of things, I didn’t even know existed. But the visual was much more salient, and I think just because, I mean, here’s a thirteen year old with arms that are scarred so badly, she’ll never be able to wear a T-shirt for the rest of her life.

Another participant talked about her own feelings of being manipulated and the potential risk in characterizing the client in this way. She said:

I had a fairly strong reaction to her, she wanted an audience . . . she walked out of that first session and I felt like I was watching an actor put on a show for me. It was a very strange experience . . . to show me the scars, which were, you know very minimal . . . and I struggled, if I confront her and it offends her, I could imagine her, coming back in two weeks with fresh scars – “look what you made me do,” a subtle manipulation happening with it.

**Subtheme 2b: The challenge of working with NSSI stimulates focused attention and heightened alertness**

Participants described being in the bind of several conflicting polarities or forces – guaranteeing confidentiality without compromising safety for the client, the desire to express understanding without encouraging or provoking the behaviour, the need for curiosity about the client’s behaviour without appearing like a voyeur or detective. There was also a very clear attempt to monitor their interpersonal reactions in the situation and immediately recognizing the need for supervision. The realization that their shock or fear could inadvertently and disconcertingly impact the client prompted them to intentionally suppress their affective response to prevent alarming the client.

I tried to not show shock or surprise . . . to kind of normalize the behaviour. Not normalize meaning “okay, it’s okay” but not to make them feel like “Oh my gosh, you did that!” and not panic. Like, I didn’t want her to feel judged . . . cause I didn’t want her to feel like she can’t tell me things.

**Subtheme 2c: Working with the uncertainty involved with NSSI stirs up feelings of incompetence**

All of the participants recognized that they were novices with no experience with this population and this provoked anxiety and doubt. The issue of their competence came up frequently in the descriptions of their sense of efficacy and this awareness often heightened their focus and allowed for increasingly anxious monitoring of their own affective and behavioural responses. A participant remembers the thought processing that occurred as she was confronted with the lack of preparedness in working with an NSSI client.
“Oh what do I do? I’ve never dealt with this before.” You know, and “What’s going on with this girl that she is doing this?” And so I think a lot of the emotions I felt were related to my status as a beginner counselor as opposed to the act itself, I was just basically afraid that I wasn’t prepared for this, that I wasn’t experienced enough to work with her.

There was also some acknowledgement that having a basic conceptual understanding of the function of NSSI did not readily inform them about what to say to the client. One participant with previous experience screening and assessing patients at a borderline personality clinic expressed considerable ambivalence about the value of her previous experience. When asked for her initial thoughts about how to work with a self-injuring client she remarked:

I really didn’t have a clue, and it was a little frightening, because even though I had encountered it in the past, all of a sudden I am supposed to be a professional counsellor . . . there were a lot of novice fears of my own expectations of how I should be dealing with this. “Am I competent enough to do it?” . . . those kinds of thing started to come up.

Subtheme 2d: Resolving ethical/legal conflicts liberates trainees to focus on emotional and behavioural issues of the client

The emergence of major ethical questions was a common experience for most of the trainees. There were the typical conflicts that clinicians often find themselves when dealing with an event that has potential risk for harm. The need to resolve the ethical mandate of ensuring that the client’s self-injury was not a manifest sign of suicide was always primary in the sequence of decisions about interventions. One participant had to revisit this scenario a second time in her work when she realized that her client was cutting again:

So I did a suicidal assessment and then I consulted with my supervisor and asked him to do the same thing, just to make sure I was, perceiving the right things. Once I felt that she was convincing me “No, I’m not suicidal, it’s not what I want” it was okay, “She wants me to keep this a secret now, so do I disclose and risk our bond? Do I keep it a secret because she has the right to confidentiality even though she’s only thirteen?” So I had a lot of different ethical things to deal with and I had to work out the ethical things in my mind.

Another trainee talked about how the session unfolded after a standard suicide assessment.

. . . after about ten minutes, I really felt he was suicidal so I was ready to take him to the hospital. I made a decision in my head that if I felt after talking with him I was worried he was going to do it, then I would take him to the hospital right then. And so after talking and doing all the strategies that we’ve talked about and had him do some relaxation stuff and it was actually very helpful. And talking more, and he felt a bit more comfortable and I felt more comfortable that he was going to be alright. And so as that point I just did the kind of the protocol where it’s not the emergency protocol . . . like I let him talk and say what he needed to say a lot. I wasn’t packed with interventions unless you call that an intervention . . . so letting him talk and express himself and I was calm, I was empathetic, just trying to really understand what he was telling me.

Theme two captures what our participants identified as being difficulties and challenges with this work. The work provokes several powerful emotions and calls for heightened awareness and effort to resolve the dilemmas present in the work.
All of the participants spoke of their feelings of incompetence; however, when they were able to work out some of the questions they had regarding their conflicts, they were somewhat more relaxed to continue with their clients. Most described themselves as feeling only less nervous as a result of this experience and not necessarily more competent or confident of their counselling efficacy with these clients.

**Theme 3: Experience provides new but incomplete learning**

This theme suggests that these experiences imparted some new clinical lessons but overall there was much uncertainty and many unanswered questions about themselves as clinicians and about working with these clients. This may have been due in part to their inability to articulate, to put into words, what learning was acquired. Additionally, we may be seeing an ongoing, active developmental process where these lessons have yet to be assimilated into new learning. Furthermore, they all spoke of the supervision they received, especially when panicked by their clients’ reports, but there is divergence with regard to the impact that supervision had on their development relative to these particular clients.

**Subtheme 3a: Keeping some interventions/questioning others**

The retrospective examination of the impact of the experience on their thinking at the time of the interview was punctuated by a number of reflections by these trainees. There was agreement that initial reactions of shock or panic needed to be well under control if work with the client was to succeed. Certainly, as they reflected on their experiences it was clear that the issue of self-harm was not so scary a topic as they had previously thought. Also, while interpersonal communication as alliance building was still seen as the main tool for intervening, there was a belief that this needed to be supported with a thorough assessment and specific strategies to reduce symptoms. Almost all of the trainees believed that they would like to be calmer and more directive with regard to assessment and symptom reduction in the future. Two trainees discuss this idea from different perspectives in the following excerpts of data:

I think I’d probably be more directive with her, I’d be less nice (laughs). I found I treated her very nicely and I think at the expense of getting into detailed analysis. I feel I would push things a bit more with her, I would challenge her more. Yeah, I’d confront her more. I don’t know, maybe I would try working more on techniques on how to avoid cutting when she was feeling the urge. Something we didn’t do a lot of...like cognitive strategies, thought stopping or something like that.

Just overly focusing on getting rid of the symptom I don’t think that’s necessarily useful, because they have a lot of shame and just focusing on the symptom might actually bring about more symptoms. I remember the beginning of my relationship with this client, she was very clear: “I don’t want to talk about this stuff because it makes me worse.” So, I think that making it more interpersonal, might be necessary, obviously a symptom reduction is a good idea, but I think it has to come once a good bond is established and once there’s an interpersonal communication going on.

**Subtheme 3b: Supervision provides mixed benefits**

While all trainees relied on supervision, especially when dealing with ethical questions, more than half of the participants suggested that supervision was
somewhat of a disappointment. A feature of our interview was to ask about their supervisory experiences vis-à-vis NSSI. Many participants spoke of the support and encouragement they received in supervision and they credited this to an increase in confidence. However, there was also a sense that supervision was a letdown in providing more specific strategies to treat the NSSI. One participant talks of individual supervision as being geared toward making her simply more open to talking to the client as a deliberate contrast to the client’s usual experience of how others react to her.

...this particular client came up in supervision quite a bit...trying to come up with strategies, to get through to her. But at the same time my supervisor is very much of the mind of, “If she needs an audience sit back and give her an audience. Maybe part of the problem is no one does”...and that really shifted my perception, there’s this sense here that maybe my reaction to her is exactly how the rest of the world reacts to her. And maybe she actually needs someone to react differently.

One trainee was confused by the mixed messages she received from the site supervisor and by the fact that neither individual nor group supervision provided the specificity that she was seeking.

My supervisor would give me encouragement, and tips on how to work with this student, but at the same time, “Oh you’re not going to change her, she’s not going to change, just leave it. Give up on her.” And so that was discouraging to me...also talking with my colleagues (university) who had students with same issue,...but nothing that really helped me with working with the student. Talking with my colleagues was just helpful in like reducing some of my stress.

To summarize the overall findings, the trainees who participated in this research had to construct a working model of NSSI when faced with their lack of knowledge of the phenomenon. They described their experience with clients who self-injured as causing powerful emotions in themselves; they highlighted the necessity to pay close attention to these emotions and the decisions they needed to take as conflicts arose, many which aroused ethical concerns for them. And finally, their reflections about the learning generated from these experiences suggested that their competence was not impacted in important ways.

**Discussion and implications**

Our analysis of interviews of counsellors in training working with clients who self-injure highlights those issues that are potentially inherent to beginners who are working with challenging cases. This is reflected by the fact that the core of the narratives was contained by theme 2 that describes the difficulties, both professional and interpersonal, that our trainees faced. What emerged were the multiple, necessary efforts that trainees engaged in as they managed emotional arousal, monitored non-verbal expressions of their reactions, assessed suicidal intent and decided on clinical strategies. Given their basic (sometimes erroneous) knowledge of NSSI and their struggle to translate this into a useful plan, trainees quickly resorted to the creation of the relational bond as their main “technique.” The trainee’s insistence on ensuring the client was being heard and validated may have taken pressure off of having to deal with the actual behaviour. Paradoxically, this “beginner’s” clinical naiveté could have had a disarming effect on the client who may have been expecting a less tentative individual. Yet, as these participants spoke of the
need to foster an empathic attitude toward the client, many acknowledged the
difficulty of maintaining this bond when the client was not engaged or when there
were fears of relapse or deterioration. In their retrospective reflections on the process
(at the end of the interview), the therapeutic alliance was seen as necessary but not
always sufficient for dealing with many aspects, behavioural and otherwise, of their
clients’ NSSI.

Consistent with the literature, our participants acknowledged that the self-
injury of their clients increased their arousal and evoked strong and at times
talk about the need for boundaries around the emotional expressions of novices
and how emotion regulation is an important skill for the trainee. Certainly our
findings resonate with this idea. To their credit, the bulk of trainees recognized that
the expression of emotion, especially as it emerged in relation to the injury itself,
could have had a deleterious effect on the fragile bond that was being established.
In fact this was an important lesson they took from the experience, to wit, that the
management and monitoring of their own affective reactions (i.e. emotion
regulation) was a critical skill, especially at the beginning of their work with an
NSSI client. Given that NSSI is considered one of the most challenging issues faced
by practitioners (Kress, 2003), the participants in our study seemed to have
understood this well.

The expectation that trainees would use their supervisory experiences to make
their work with clients more effective was not fully borne out. It was clear that
refuge in the supervisor was a consistent report among all participants when they
became aware of their fears and lack of competence with NSSI. Trainees were
provided with individual supervision at their sites and group supervision at their
academic institution and yet while our interview protocol allowed for a thorough
exploration of the impact of supervision, the narratives were absent of what might
be considered rich descriptions and recollections of supervisory experiences. This is
somewhat unexpected since all trainees spoke of the need for supervision, often
times at the moment when a client reported the self-injurious behaviour. The
general reports were that supervisors tended to be supportive and encouraging of
their efforts as novices and this seemed to counteract some of their fears of
inadequacy. Yet, the majority of participants described their supervision as lacking
in direct guidance, either with respect to case management or with ways to improve
their own learning and development as clinicians. Thus, our finding that
supervision was not seen as more salient in their experience may have been the
result of an unspoken disagreement about the goals of supervision. Trainees
seemed to be expecting specific, discrete techniques as their goal whereas
supervisors may have been more focused on getting the trainee to relax and to
trust their basic training in listening, validating, and providing empathy and
understanding.

A final observation of our analysis of the experiences of our participants was the
lack of a cohesive narrative of their development in light of the experience.
Participants often presented a fragmented, difficult-to-articulate understanding of
their learning when asked about the overall impact of the experience. One might find
this peculiar given that their reported sense of efficacy increased as their discomfort
decreased. Yet, this emergent tacit knowledge was not converted into a more
nuanced and complex understanding of their work or the phenomenon of NSSI.
It was clear that the main clinical issue for them was a focus on ‘procedural
knowledge’’ in a constant attending to the question of ‘‘What do I do now’’? Supervision is often the crucible where procedural questions can be addressed while simultaneously asking about the more complex aspects of professional development. This is usually done by a focus on metacognitive skills and the capacity to reflect on one’s own work as an antidote to feelings of incompetence (Hatcher & Lassiter, 2007; Skovholt, Ronnestad, & Jennings, 1997). Thus, we are left wondering how these trainees might have been impacted additionally by their experiences had they used their supervisory time to capitalize on these tasks.

Given the extent of NSSI among adolescents and young adults, mental health professionals working in all types of settings will likely find themselves with one or more NSSI clients on their caseloads. This implies that the mental health generalist (e.g. school counsellor) and not the specialist will be providing treatment to this population. Yet this reality seems to have evaded the attention of clinical training and supervision (Hoffman & Kress, 2008). That our trainees have a rudimentary, intellectual understanding of NSSI and used only the basic relational skills in their work could potentially be seen as a deficiency. However, it can also be seen as strength in that true to established practices, the therapeutic relationship is the core competency to be implemented regardless of the context or presenting problem. While a strong focus on the development of relational skills may continue to be sound advice from supervisors, the results of this study nonetheless imply that we also need to be providing more specific tools to effectively intervene with clients who are seen as highly challenging and difficult to treat.

Limitations
As with all exploratory research, the findings of this study are suggestive. While the sample size and procedure for participant selection and data analysis were appropriate for this design, transferability is limited. Participants were a sample of convenience, drawn from a Master’s level cohort and although this is not unusual in qualitative research, it may raise questions about the representativeness of the experiences. Furthermore, our findings are based on the participants’ reports. A significant amount of information may have been inaccessible or even deliberately suppressed. Interviewing the participants on different occasions and timing the interview in a way where trainees may have had access to their case notes would have strengthened the reliability of their recall. More prominently, the methodology did not include triangulation for other sources of information as only participant perspectives were collected. Had supervisors, case notes or recorded sessions been available, this would have added more credibility to what they reported.

Finally, the findings describe the experiences of trainees who were white women of Anglo-European background. While the clients came from diverse educational settings, our interview protocol did not address diversity. It is reasonable to assume that this dimension may have had an impact on our trainees’ experiences.

Conclusions
While the context of this qualitative study was on novices’ experiences working with clients with NSSI, any of a number of difficult issues or client populations may have
produced a very similar pattern of findings. In this sense, NSSI was used as a proxy for understanding how novices deal with the demands of a challenging population. The unsettling nature of self-injury and the limited knowledge about how to address it converged to heighten trainees’ sense of alarm and panic which had to be managed if the work was to proceed with a measure of confidence. Certainly, the immediate, negative emotions that the presenting problem elicited in our participants were an important feature of their experience and probably interfered with task performance. Yet as incompetence was openly acknowledged, it was accompanied by vigilance and a self-observational quality typical of self-monitoring and reflexivity that are hallmarks of good practice. As trainers, this provokes us to think about the optimal number of complex or difficult cases needed to instill the kind of thoughtfulness and self-examination required for competence and lifelong learning. It will be left to future research to see whether an appropriate level of experience is one where the trainee is kept in a steady state of creative tension that never overwhelms or erodes their fragile sense of competence. Of course, supervision, and especially a strong supervisory alliance where the supervisor invests and believes in the trainee’s abilities, is one vehicle for managing this creative tension.

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